



## TEXAS DEPARTMENT OF INSURANCE

### Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

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## **MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION**

### **GENERAL INFORMATION**

**Requestor Name**

FONDREN ORTHOPEDIC GROUP LLP

**MFDR Tracking Number**

M4-17-0724-01

**MFDR Date Received**

November 14, 2016

**Respondent Name**

PETROLEUM CASUALTY CO

**Carrier's Austin Representative**

Box Number 01

### **REQUESTOR'S POSITION SUMMARY**

**Requestor's Position Summary:** "We are submitting this reconsideration on regards to procedure code Q4006. According to Medicare Guidelines this code is a payable code. Therefore we should receive payment for this code."

**Amount in Dispute:** \$50.00

### **RESPONDENT'S POSITION SUMMARY**

**Respondent's Position Summary:** "Per Medicare, HCPCS code Q4006 has a fee schedule status code of X which indicates a statutory exclusion. These codes represent an item or service that is not in the statutory definition of 'physician services' for fee schedule payment purposes under any circumstances. NO RVUS or payment amounts are shown for these codes, and no payment may be made under the physician fee schedule."

**Response Submitted by:** CorVel Healthcare Corporation

### **SUMMARY OF FINDINGS**

Date(s) of Service	Disputed Service(s)	Amount In Dispute	Amount Due
June 20, 2016 and July 6, 2016	Q4006 x 2	\$50.00	\$0.00

### **FINDINGS AND DECISION**

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all-applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

**Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.305 sets out the procedure for dispute resolution.
3. 28 Texas Administrative Code §133.308 sets out the procedure for resolving medical necessity disputes.
4. 28 Texas Administrative Code §134.600 sets out the guidelines for preauthorization, concurrent review, and voluntary certification of healthcare.
5. 28 Texas Administrative Code §134.203 sets out the fee guidelines for the reimbursement of workers' compensation professional medical services provided on or after March 1, 2008.
6. The services in dispute were reduced/denied by the respondent with the following reason codes:
  - RP3 – CMS statutory exclusion/svc not paid to physicians
  - P14 – Payment is included in another svc/procdre occurring on same day
  - 182 – Reviewed as no charge
  - W3 – Appeal/reconsideration

## Issues

1. What are the denial reason(s) raised by the insurance carrier during the bill review process?
2. What are the Medicare payment policies for HCPCS Code Q4006?
3. Is the requestor entitled to reimbursement?

## Findings

1. The requestor seeks reimbursement for HCPCS Code Q4006 rendered on June 20, 2016 and July 6, 2016. The insurance carrier denied the disputed service with denial reason code(s) "RP3 – CMS statutory exclusion/svc not paid to physicians" and "P14 – Payment is included in another svc/procdre occurring on same day."
2. 28 Texas Administrative Code §134.203 (b) states in pertinent part, "For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules."

The Division completed NCCI edits to identify potential edit conflicts that may affect reimbursement. The following was identified:

"Per Medicare guidelines the procedure code is an item or service that is not in the statutory definition of physician services for fee schedule payment purposes. No RVUS or payment amounts are shown for this code(s), and no payment may be made under the physician fee schedule."

The Division finds that the disputed services were rendered in an office setting with place of service code "11" indicated on the CMS-1500. The physician fee schedule therefore applies to the dispute service. As a result, the requestor is not entitled to reimbursement for HCPCS Code Q4006 as Medicare not does allow for payment to be made under the physician fee schedule.

3. Review of the submitted documentation finds that the requestor is not entitled to reimbursement for HCPCS Code Q4006 rendered on June 20, 2016 and July 6, 2016.

## Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is \$0.00.

## **ORDER**

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

## Authorized Signature

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Medical Fee Dispute Resolution Officer

December 16, 2016  
\_\_\_\_\_  
Date

## **YOUR RIGHT TO APPEAL**

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

***Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.***